SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM

INSTITUTIONAL BILLING MANUAL

INSTITUTIONAL MANUAL
TABLE OF CONTENTS

INTRODUCTION

This manual is one of a series published for the use of medical services providers enrolled in the South Dakota Medical Assistance Program. It is designed to be readily updated by replacement or addition of individual pages as necessary. When such changes occur, supplementary pages will be sent to participating providers. It is designed to be used as a guide in preparing claims, and is not intended to address all Medical Assistance Program rules and regulations.

Problems or questions regarding Medical Assistance Program rules and policies should be directed to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291
E-Mail: Medical@dss.state.sd.us
PHONE: (605) 773-3495

If you are not currently submitting claims electronically and are interested in doing so, please contact our office for further information.

PROVIDER TOLL FREE NUMBER 1-800-452-7691

Questions on Medical Assistance Program claims, covered services or eligibility verification can be directed to the above address or contact the Medical Assistance Program Provider Support Unit at *1-800-452-7691. The phone unit will not give out recipient ID numbers. The Medical Assistance Program emphasizes both the recipient's responsibility to present their ID card and the provider's responsibility to see the ID cards each time a recipient obtains services (other than true emergency services.) It is to the provider's advantage to see the ID card to verify that the recipient is Medical Assistance Program eligible at the time of service, as well as identify any other program limitations and the listing of the recipient name on the Medical Assistance Program file.

***Toll free telephone number is NOT to be given to recipients. This number is only to be used by the provider.**

Problems or questions concerning recipient eligibility requirements can be handled by contacting the local field office of the Department of Social Services in your area or should be directed to:

Department of Social Services
Division of Economic Assistance
700 Governors Drive
Pierre, South Dakota 57501-2291
PHONE: (605) 773-4678

Medicare is a separately administered federal program and questions concerning Medicare cannot be answered by Medical Assistance Program personnel.

CHAPTER I
GENERAL INFORMATION

The purpose of the Medical Assistance program (Title XIX) is to assure the availability of quality medical care to low-income individuals and families through payments for a specified range of services. The Medical Assistance Program was implemented in South Dakota in 1967.

Federal and state governments under Title XIX of the Social Security Act share funding and control of the Medical Assistance program. Regulations are written to comply with the actions of Congress and the State Legislature.

The following sections provide a description of general information about the program. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing the Medical Assistance program in Article 67:16.

PROVIDER RESPONSIBILITY

ENROLLMENT AGREEMENT

A provider who renders a covered service to an eligible South Dakota Medical Assistance recipient and wishes to participate in the Medical Assistance program must apply to become an enrolled provider. The provider must sign a Provider Agreement with the Department of Social Services Division of Medical Services. Providers must comply with the terms of participation in the agreement and requirements stated in ASRD 67:16 which govern the Medical Assistance program. Failure to comply with these requirements may result in monetary recovery, and/or civil or criminal action.

An agreement with a participating provider does not become effective until the department has approved and signed the agreement. A provider may not request reimbursement for covered services provided before the effective date, written on the provider agreement.

Participating providers agree to accept Medical Assistance program reimbursement as payment in full for covered services. The provider must NOT bill any of the remaining balance to the recipient, their family, friends or political subdivisions.
An individual (i.e. employee, contractual employee, consultant etc.) who does not have a provider agreement, but who furnishes a covered service to a recipient under an employer's agreement and receives payment or benefits indirectly from the Department of Social Services, is also subject to the rules, regulations and requirements of the Medical Assistance program.

TERMINATION – AGREEMENT

When a provider agreement has been terminated the Department of Social Services (DSS) will not pay for services provided after the termination date. A provider agreement may be terminated for any one of the following reasons:

1. The agreement expired;
2. The provider failed to comply with conditions of participation of the signed provider agreement;
3. The ownership, assets, or control of the provider's entity were sold or transferred;
4. Thirty days have elapsed since DSS requested the provider to sign a new provider agreement;
5. The provider requested termination of the agreement;
6. Thirty days elapsed since DSS provided written notice to the provider of its intent to terminate the agreement;
7. The provider has been convicted of a criminal offense that involves fraud in any state or federal medical assistance program;
8. The provider is suspended or terminated from participating in Medicare;
9. The provider's license or certification was suspended or revoked; or
10. Due to inactivity.

OWNERSHIP CHANGE

A participating provider who sells or transfers ownership or control of the entity must give DSS written notice of the pending sale or transfer at least 30 days before the effective date. In a change of ownership, the seller is responsible for maintaining and ensuring access to records generated prior to the sale. This responsibility may be transferred to the buyer through a sales contract or written agreement. The Medical Assistance program provider number is NOT transferable to the new owner. The new owner must apply for and sign a new provider agreement and a new number must be issued before claims can be submitted.

RECORDS

Providers must keep legible medical and financial records that fully justify and disclose the medical necessity and extent of services provided and billed to the Medical Assistance program. These records must be retained for at least six years after the last remittance date a claim was paid or denied. Records must not be destroyed when an audit or investigation is being conducted. Agencies involved in the Medical Assistance program review or investigation must be granted access to these records.

CLAIM SUBMISSION

The provider must submit the claim to a third-party liability source before submitting it to the DSS with the exception of for the following:

- Prenatal care;
- Dental or orthodontic services;
- Optical services;
- Nursing home care;
- Annual Psych Deductible is met; and
- HCBS Elderly Waiver services.

The claim submitted to DSS must have the notice of third-party payment or rejection attached to the claim. Failure to attach the notice to each claim will be cause for denial of the claim.

PAYMENTS

Once the provider has identified a third-party source, and prior to requesting payment, a completed claim for services must be submitted for payment to the third-party source. When the claim is subsequently submitted to the department for payment, evidence of third-party payment or rejection must accompany the claim. The provider is eligible to receive the amount allowed under the department's payment schedule less the third-party liability payment amount.

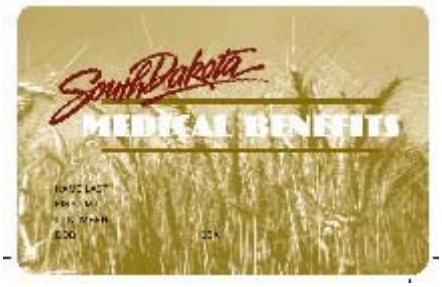
When the third-party payment equals or exceeds the amount allowed under the Medical Assistance program, the provider must not seek payment from the recipient, relative, or any legal representative.

MEDICAL ASSISTANCE PROGRAM RECIPIENT ELIGIBILITY AND POLICIES

The South Dakota Medical Assistance Identification Card is issued by DSS on behalf of eligible Medical Assistance program recipients. The magnetic stripe card has the same background as the Food Stamp EBT card. The information on the face of the card includes the recipient's complete name (first, middle initial, and last), the nine digit recipient ID (RID#) plus a three digit generation number, and the recipient's date of birth and sex.

Note: The three digit generation number is automatically added in the system to indicate the number of cards sent to an individual. This number is not part of the recipient's ID number and should not be entered on the claim.

Each card has only the name of an individual on it. There are no family cards.
Recipients must present their identification card to a Medical Assistance provider each time, before obtaining a covered service. Failure to present the Medical Assistance program identification card is cause for payment denial. Payment for denied services becomes the responsibility of the recipient.



Medicaid Eligibility Verification System (MEVS) offers three ways for a provider to access the state's recipient eligibility file.

- *Point of Sale Device*: Through the magnetic strip, the provider can swipe the card and in about 10 seconds have an accurate return of eligibility information.
- *PC Software:* The provider can key enter the RID# into PC software and in about 10 seconds have an accurate return of eligibility information.

- *Automated Voice Response:* The provider who does not purchase equipment to access the plastic card will need to call the Division of Medical Services' at, 1-800-452-7691 and receive eligibility information through the Automated Voice Response. This process takes approximately 1:15 minutes to complete a transaction and is only capable of reporting current (no previous) eligibility information.

NOTE: Please listen to the entire message when calling the Voice Response System.

MEVS ELIGIBILITY INFORMATION

Through the MEVS (card swipe or PC entry) the provider receives a paper or electronic receipt ticket, immediately upon eligibility verification (approximately 10 seconds). The following is an example of the "ticket' sent to the provider.

Please note that certain Medical Assistance program recipients are restricted to specific limits on covered services. It is very important that you check for restrictions.

**********SD MEDICAL BENEFIT **********

Eligibility
8/19/2004 14:06:31

PAYER INFORMATION

Payer: SOUTH DAKOTA MEDICAL SERVICES
Payer ID: SD99MED

PROVIDER INFORMATION

Provider: MID-DAKOTA HOSP
Service Provider #: 0009999

SUBSCRIBER INFORMATION

Current Trace Number: 200408191408031
Assigning Entity: 9000000099
Insured or Subscriber: Doe, John
Member ID: 000999999
Address: 215 Pacific Ave.
Wood, SD 570316603
Date of Birth: 10/15/1982
Gender: Female

ELIGIBILITY AND BENEFIT INFORMATION

HEALTH BENEFIT PLAN COVERAGE
ACTIVE COVERAGE
Insurance Type: Medicaid
13
Eligibility Begin Date: 04/08/2004

ACTIVE COVERAGE
Insurance Type: Medicare Primary
12
Eligibility Date Range: 08/19/2004 –
08/19/2004

HEALTH BENEFIT PLAN COVERAGE
OTHER OR ADDITIONAL PAYER

Insurance Type: Other
Benefit Coord. Date Range: 08/19/2004 –
08/19/2004

Payer: UNITED MEDICAL RESOURCES
Address: PO BOX 99999
Cincinnati, OH 45999

Information Contact:
Telephone: (800)662-0384

TRANS REF # 303999999

CLAIM STIPULATIONS

FORMS

Providers are required to use the National Standard Form (UB-04) to submit claims.

SUBMISSION

The provider must verify an individual's eligibility before submitting a claim, either through the ID card or in the case of long-term care, a letter from the caseworker. The provider must record the recipient identification information as required for the claim. **A provider may only submit claims for Medical Assistance program**. A provider must not submit a claim for items or services that have not been completed or have not actually been provided. **A provider can be reimbursed only for medically necessary covered services actually provided** to Medical Assistance program recipients eligible on the date the service is provided.

Electronic claim filing

If you do not currently file claims electronically, please consider doing so in the near future. Electronic filing offers you several advantages, including:

- Claims are entered into the system directly, with less human intervention;
- Claims may be entered any time of day, any day;
- Claim filing deadlines are more generous;
- Claims are paid more quickly and more accurately; and
- Electronic filing costs are offset by the efficiency.

Electronic claims must be submitted using the 837I, HIPAA-compliant X12 format

TIME LIMITS

The DSS Division of Medical Services must receive a completed claim form within 12 months following the month the service was provided. This time limit may be waived or extended only if one or more of the following situations exist:

1. The claim is a replacement or void of a previously paid claim, and is received within six months after the previously paid claim;
2. The claim is received within six months after a retroactive initial eligibility determination was made as a result of an appeal;

3. The claim is received within six months after a previously denied claim;
4. The claim is received within six months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or
5. To correct an error made by the department.

PROCESSING

The Division of Medical Services processes ***paper*** **claims** submitted by providers in the following manner:

1. Claims and attachments are received by the Division of Medical Services and sorted by claim type and microfilmed;
2. Each claim is given a unique 14-digit Reference Number. This number is used to enter, control, and process the claim. An example of a reference number is 2004005-0011480. The first four digits represent the year. The next 3-digits represent the day of the year the claim was received. The next 7-digits are the sequential number order of the claims received on that day. Each line is separately adjudicated, reviewed and processed using the 14-digit reference number. However, claims with multiple lines will be assigned a single claim reference number.
3. All claims are separately entered into the computer system and will be completely detailed on the remittance advice.

To determine the status of a claim, you must reconcile your files with the information on the Remittance Advice.

UTILIZATION REVIEW

The Federal Government requires states to verify receipt of services. Each month a sample of Medical Assistance program recipients are sent a survey letter requesting verification of services paid the previous month on their behalf. Such services are identified in non-technical terms, and confidential services are omitted. Although the directions are as clear as possible, providers should be prepared to assure any inquiring recipients that this letter is not a bill.

Under 42 C.F.R. part 456, the Medical Assistance program is mandated to establish and maintain a surveillance and utilization review system (SURS). The SURS unit safeguards against unnecessary or inappropriate use of Medical Assistance services or excess payments, assesses the quality of those services, and conducts a post-payment review process to monitor both the use of health services by recipients and the delivery of health services by providers.

Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by the Medical Assistance program.

FRAUD AND ABUSE

The SURS unit is responsible for the identification of possible fraud and/or abuse. The Medicaid Fraud Control Unit (MFCU) under the Office of the Attorney General is certified by the Federal Government to detect, investigate, and prosecute any fraudulent practices or abuse against the Medical Assistance program. Civil or criminal action or suspension from participation in the Medical Assistance program is authorized under South Dakota Codified Law (SDCL) 22-45.

It is the provider's responsibility to become familiar with all sections of SDCL 22-45 and ARSD Article 67:16.

DISCRIMINATION PROHIBITED

Medical Assistance providers and contractors may not discriminate against Medical Assistance recipients on the basis of race, color, national origin, age, sex or disability. All enrolled Medical Assistance providers must comply with this non-discrimination policy.

MEDICALLY NECESSARY

Medical Assistance covered services are to be payable when the service is determined medically necessary by the provider. To be medically necessary, the covered service must meet all of the following conditions:

1. It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
2. It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
3. It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
4. It is not furnished primarily for the convenience of the recipient or the provider; and
5. There is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

CHAPTER II
HOSPITAL PROVIDER COVERED SERVICES AND REIMBURSEMENT

COVERED INPATIENT SERVICES

The following **inpatient hospital** services are covered under the Medical Assistance program:

1. Semiprivate room accommodations and board. Private rooms are covered when justification by a statement of medical necessity from the attending physician;
2. Regular nursing services routinely furnished by a hospital;
3. Supplies, such as splints and casts, and use of appliances and equipment, such as wheelchairs, crutches, and prostheses;
4. Whole blood or packed red cells;
5. Diagnostic services;
6. Therapeutic services;
7. Operating and delivery rooms;
8. Drugs and biologicals ordinarily furnished by the hospital;
9. Medical social services;
10. Services of hospital residents and interns who are in approved training programs;
11. Dialysis treatments;
12. Services of hospital-based physicians;
13. Sterilizations authorized under § 67:16:02:09 and
14. Hysterectomy authorized under § 42 C.F.R. 441.250 to 441.259, inclusive (October 1, 1989).

COVERED OUTPATIENT SERVICES

The following **outpatient hospital** services are covered under the Medical Assistance program:

1. Laboratory services;
2. X-ray and other radiology services;
3. Emergency room services;
4. Medical supplies used during treatment at the facility;
5. Physical therapy, speech therapy, and occupational therapy when furnished by or supervised by a licensed therapist and periodically reviewed by a physician;

Exception: When all of the above services are listed in a child's individual education plan (IEP) the services are to be billed by the school district. (ARSD § 67:16:37)

6. Whole blood or packed red cells;
7. Drugs and biological which cannot be self-administered;
8. Dialysis treatments;
9. Services of hospital – based physicians and/or hospitalities are to be billed on a CMS 1500 claim form;

10. Outpatient surgical procedures, including those procedures contained in ARSD § 67:16:03 Appendix A ;
11. Sterilizations authorized under ARSD § 67:16:02:09;
12. Hyperbaric oxygen therapy if the requirements of ARSD § 67:16:02:05.08 and § 67:16:02:05.09 are met; and
13. Cardiac rehabilitation – Phase II.

NON-COVERED SERVICES

The following **inpatient hospital** services are not covered:

1. Physician's services other than services by residents and interns in training;
2. Private duty nursing services;
3. Personal comfort or convenience items;
4. Organ transplants except as authorized under the provisions of ARSD § 67:16:31;
5. Custodial care;
6. Autopsies; and
7. Chemical dependency or chemical abuse treatment services.

INPATIENT PSYCHIATRIC HOSPITAL

All inpatient psychiatric hospital services provided in an exempt free standing psychiatric unit ***must*** be prior authorized under the provisions of ARSD § 67:16:03:02.01.

The following psychiatric hospital services are not covered:

1. Out-patient psychiatric hospital services; and
2. Freestanding psychiatric hospital services are not payable for adults.

PAYMENT OF HOSPITAL SERVICES

Payments shall be made for covered services rendered to eligible South Dakota Medical Assistance Program recipients for medical necessary services provided on an inpatient or outpatient basis and for the deductible and coinsurance under the Medicare program.

A readmission to the same hospital for the same diagnosis on the same day as the day of discharge is considered a continuation of the prior admission for payment purposes.

Readmission or return to a hospital following a leave of absence, regardless of length, is not considered a separate admission.

The attending physician, the physician's representative, or the hospital must obtain prior authorization from the department or the department's authorized representative before inpatient hospital service listed in ARSD § 67:16:03 Appendix C are provided. If a service is provided without an authorization in an inpatient setting and is determined the service could have been provided in an outpatient setting, the department shall reimburse the service at an outpatient rate.

The required service is exempt from the provisions of this section if it is provided as the result of an emergency or the individual is already an inpatient at the treatment facility at the time the service is determined to be necessary.

BASIS OF REIMBURSEMENT

A claim for services provided must be submitted at the hospital's usual and customary charge to the general public. Reimbursement is based on the following:

HOSPITALS WITH MORE THAN 30 MEDICAL ASSISTANCE DISHCHARGES

Reimbursement for services provided to a patient admitted to an in-state acute care hospital that had more than 30 Medical Assistance program discharges during the hospital's fiscal year ending after June 30, of the most current fiscal year, and before July 1, of the most current fiscal year, is based on DRG's weight factors, the hospital's target amount, per diem capital and education costs per day. A list of the DRG's and their associated weight factors are available on the department's website located at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp.

A cost outlier reimbursement may be made in addition to the regular DRG reimbursement for a claim qualifying as an outlier as defined in ARSD § 67:16:03:01. The amount of the cost outlier payment is equal to 90 percent of the cost outlier.

The method of calculating the amount of reimbursement may be found at ARSD § 67:16:03:06.

If a patient is transferred, referred, or discharged to another hospital or another type of special care facility and the transfer, referral, or discharge is medically necessary or if a patient leaves the hospital against medical advice, reimbursement is on a per diem basis up to 100% of the reimbursement of the DRG.

OUTPATIENT SERVICES INCURRED WITHIN THREE DAYS IMMEDIATELY PRECEDING THE INPATIENT STAY

Cost for outpatient services incurred within three days immediately preceding the inpatient stay are included in the inpatient charges unless the outpatient service is not related to the inpatient stay. This provision applies only if the facilities providing the inpatient and outpatient services are owned by the same entity. During an inpatient stay all hospital costs are an intricate part of the inpatient stay, including services provided by another hospital.

HOSPITALS WITH LESS THAN 30 MEDICAL ASSISTANCE DISCHARGES

Reimbursement for in-state inpatient hospital services provided by a hospital with less than 30 Medical Assistance discharges during the hospital's fiscal year ending after June 30, of the most current fiscal year, and before July 1, of the most current fiscal year is a percentage of the hospital's usual and customary charge. For the current percentage please refer to ARSD § 67:16:03:06.03

OUT-OF-STATE HOSPITALS

The department shall reimburse out-of-state inpatient hospital services by making a prospective payment equal to the payment allowed by the Medical Assistance program in the state in which the hospital is located. If the Medical Assistance program in the hospital's home state refused to price a claim the payment allowed is a percentage of the provider's usual and customary charge. For the current percentage please refer to § 67:16:03:06.03.

OUTPATIENT SERVICES

SERVICES OTHER THAN OUTPATIENT LABORATORY AND OUTPATIENT SURGICAL PROCEDURES

- Reimbursement for outpatient hospital services for an in-state acute care hospital that has more than 30 inpatient Medical Assistance Program discharges in the hospital's fiscal year ending after June 30, of the most current fiscal year, and before July 1, of the most current fiscal year, is based on reasonable costs with the following exceptions:
  (a) Costs associated with the hospital employed certified registered nurse anesthetist services that relate to outpatient services are included as allowable costs; and
  (b) All capital and education costs incurred for outpatient services are included as allowable costs.
- Reimbursement for outpatient hospital services for the remaining in-state acute care hospital is at 90 percent of their usual and customary charge for the service provided.
- Reimbursement for out-of-state hospital outpatient services is according to the average reimbursement as of June 30, of the most current fiscal year, for the services provided in in-state hospital that had more than 30 Medical Assistance program discharges in their fiscal year ending after June 30, of the most current fiscal year and before July 1, of the most current fiscal year.
- For outpatient services incurred within three days immediately preceding the inpatient stay, are included in the Inpatient Services located on page 13 of this manual.

OUTPATIENT LABORATORY SERVICES

All outpatient laboratory services are reimbursed according to the Outpatient Laboratory fee schedule located on the department website at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp. If no fee for a procedure is established, reimbursement is a percentage of the provider's usual and customary charge for the service as sited in § 67:16:03.06 and § 67:16:03.07.

OUTPATIENT SURGICAL HOSPITAL CLASSIFICATION AND REIMBURSEMENT

A hospital which provides ambulatory surgical procedures listed in Appendix A of ARSD § 67:16:28 will be assigned a classification dependant on number of beds or specialization listed below:

1. A hospital with 60 beds or less is classified as Class I;
2. A hospital with more than 60 beds is classified as Class II; and
3. A specialized surgical hospital located in a city that has an ambulatory surgical center or a specialized surgical hospital or an out of state facility is considered a Class III.

Basis of reimbursement for an ambulatory surgical procedure is then calculated dependant on the following:

1. When the procedure **is not** contained in Appendix A of ARSD § 67:16:28, payment is calculated according to ARSD § 67:16:03:06.01;
2. When the procedure is contained in Appendix A of ARSD § 67:16:28 and falls into payment group of 1, 2, 3, or 4, multiply the assigned payment amount to the payment group listed below:

GROUP	PAYMENT
Group 1	$240
Group 2	322
Group 3	369
Group 4	452

By one of the following appropriate hospital classifications:

Class I,	1.25%;
Class II,	1.10%; or
Class III,	1.00%.

3. When a surgical procedure is listed in Appendix A of ARSD § 67:16:28 and the procedure falls into a payment Group 5, the basis of reimbursement is calculated according to ARSD § 67:16:03:06.01.
4. When more than one surgical procedure is performed in a single operating session or on the same day and all the procedures are contained in Appendix A of ARSD § 67:16:28 and have a payment group of 1, 2, 3, or 4, the procedure with the highest reimbursement rate is payable at 100 percent of the calculated rate explained in Basis of Reimbursement above.
5. When more than one surgical procedure is performed in a session or on the same day and any one of the surgical procedures are not listed in Appendix A of ARSD § 67:16:28 and have a payment group of 1, 2, 3, or 4, reimbursement is determined according to § 67:16:03:01. However, if the CPT code not listed in Appendix A is 10040, 16000, 31725, 36000, 36400, 36405, 36406, 36410, 36415, 36600, 46900, 51000, 53670, 53675, 571150, 58300, 58301, or 69090, reimbursement is allowed for the procedure not listed; and
6. When the surgical procedure is necessary to prevent the death or serious impairment of the health of the recipient after the sudden onset of a medical condition that is manifested by symptoms of sufficient severity so as to be life-threatening or requires immediate medical intervention and the claim is coded as an emergency the rate of reimbursement is determined according to ARSD § 67:16:03:06.01.

DRG – EXEMPT HOSPITAL UNITS

In-state freestanding rehabilitation hospitals, public health service hospitals, acute hospital with less than 30 Medical Assistance discharges during their fiscal year ending after June 30, of the most current fiscal year and before July 1, of the most current fiscal year, and the State of South Dakota Children's Hospital are exempt from DRG reimbursement provisions.

South Dakota Medical Assistance program may exempt in-state intensive care nursery units from DRG reimbursements on request by the hospital if all costs and statistics relating to the operation of the unit are identifiable and if the unit meets the following criteria:

1. Provides care for infants under 750 grams;
2. Provides care for infants on ventilators;
3. Provides major surgery for newborns;
4. Has 24 hour coverage by a neonatologist; and
5. Has a maternal neonatology transport team.

The Medical Assistance program may exempt a psychiatric unit and a rehabilitation unit from DRG reimbursement on request by the hospital if all costs and statistics relating to the operation of the unit are identifiable.

Reimbursement for in-state DRG-exempt hospitals and units is based on reasonable and allowable costs with the following exceptions:

1. Costs associated with non-hospital certified registered nurse anesthetist that relate to exempt units of hospital are included as allowable costs;
2. Capital and education costs incurred for inpatient services are included as allowable costs; and
3. Psychiatric unit services are paid at the lesser of usual and customary charges for services provided or a daily rate of $580 plus an annual inflationary factor.

RURAL CRITICAL ACCESS HOSPITALS

If the Department of Health determines that a hospital is an above-average, critical access-critical hospital or at-risk hospital, reimbursement is the greater of reasonable costs determined under the provisions of ARSD § 67:16:03:06.01 or the payment otherwise reimbursable under this chapter.

DISPROPORTIONATE SHARE HOSPITALS

To qualify as a disproportionate share hospital a hospital must meet the following requirements:

1. Have a Medical Assistance inpatient utilization rate that is above the mean Medical Assistance inpatient utilization rate for hospitals receiving Medical Assistance payments in the state or have a low-income utilization rate that exceeds 25 percent.
2. Have a Medical Assistance utilization rate of at least one percent; and
3. Have at least two obstetricians who have staff privileges at the hospital and have agreed to provide obstetric services to individuals eligible for the Medical Assistance.

MAXIMUM RATE OF PAYMENT

When an infant is transferred between a DRG-reimbursed hospital unit and a DRG-exempt intensive care nursery unit (NICU) within the same hospital, the total reimbursement for the combined care in the units may not exceed the amount payable had all needed services been delivered in the NICU.

STERILIZATION AND HYSTERECTOMIES

Federal regulations relate to the requirements which enable the state to receive federal matching funds for sterilizations and hysterectomies. The Federal regulations must be met in order for the state to receive federal funds. The Medical Assistance program office will deny payment to physicians, hospitals, surgi-clinics, anesthesiologists, anesthetists, or any provider billing for services involving sterilization or hysterectomies **unless the Consent Form for Sterilization or Acknowledgment of Information for Hysterectomies** are in compliance.

STERILIZATION (MALE AND FEMALE)

The Medical Assistance program sterilization consent form must be accurately completed and attached to the claim. Instructions for completing the form are as follows:

INFORMED CONSENT

Informed consent consists of the following:

1. Providing a copy of the consent form to the individual to be sterilized;
2. Offering to answer any questions the individual has about sterilization;
3. Giving the following information to the person to be sterilized;
    a. That they may withdraw their consent at any time prior to sterilization and that the withdrawal will not affect any program benefits.
    b. A description of alternative methods of birth control;
    c. That the procedure is considered to be irreversible;
    d. An explanation of the sterilization procedure to be performed;
    e. An explanation of discomforts and risks of the sterilization procedure, including anesthetic risks;
    f. A full description of the benefits that may be expected; and
    g. That sterilization cannot be performed for at least 30 days except for circumstances listed under "Exceptions".
4. Arrangements shall be made to effectively inform the blind, deaf, and those who do not understand the language.

Informed consent may not be obtained while the individual is to be sterilized if:

1. In labor or child birth;
2. Seeking to obtain or obtaining an abortion; or
3. Under the influence of alcohol or drugs.

EXCEPTIONS:

In the event of a premature delivery, the following must occur:

1. The consent form must be signed by the individual to be sterilized at least 30 days prior to expected delivery date and at least 72 hours prior to the sterilization; and
2. The date of the expected delivery must be written on the consent form;

In the event a sterilization is performed during an emergency abdominal surgery, the following must occur:

1. The consent form must be signed by the individual to be sterilized at least 72 hours prior to sterilization; and
2. The physician must describe the surgery and explain the medical necessity of the emergency abdominal surgery.

NOTE: A sterilization is not considered an emergency.

CONSENT FORM INSTRUCTIONS

The consent form must be signed by the recipient <u>at least 30 days</u> and no more than 180 days prior to sterilization surgery.

THE CONSENT FORM MUST CONTAIN:

1. Doctor's or clinic's name;
2. Name of surgery;
3. Month, day, and year of the (recipient's) birth;
4. Recipient's name;
5. Name of the doctor who will be performing the surgery;
6. Name of the surgery (same as #2 above).
7. Recipient's signature; and
8. Month, day and year the recipient signed the form.

INTERPRETER'S STATEMENT

This section must be fully completed whenever the recipient being sterilized cannot fully understand or speak English and show:

1. The recipient's native language; and
2. Signature of the interpreter and the date the information was provided.

STATEMENT OF PERSON OBTAINING CONSENT

This section must include the following:

1. Name of the individual requesting the sterilization;
2. Name of the surgery to be performed (same as #2);
3. Signature of the person obtaining the consent and witnessing the recipient's signature and the date consent was obtained (the date should be the same as #8);
4. Name of the facility or agency the individual represents;
5. Mailing address of the facility or agency.

PHYSICIAN'S STATEMENT

This section must include the following:

1. Name of recipient;
2. Date of surgery (must be 30 days or more after #8);
3. Name of surgery performed (same as #2);
4. Signature of physician who performed the surgery; and
5. Date of physician's signature (<u>this signature must be after the surgery is completed).</u>

NOTE: A copy of the consent form must be attached to all sterilization claims submitted to Medical Assistance Program.

DSS-MS-146 (Revised 11/89) **MEDICAID STERILIZATION CONSENT FORM**

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAM OF PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____.
(Doctor or Clinic)

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible. I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN. I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction. I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs. I am at least 21 years of age and was born on _____
Month/Day/Year

I, _____, hereby consent of my own free will to be sterilized by _____ by a method called _____. My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare, Or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed. I have received a copy of this form.

_____Date:_____
Signature *Month/Day/Year*

You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check)

☐ American Indian or Alaska Native ☐ Hispanic

☐ Black (not of Hispanic origin) ☐ Asian or Pacific Islander

☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ Date: _____
Interpreter *Month/Day/Year*

■ STATEMENT OF PERSON OBTAINING CONSENT

Before _____
Name of Individual

signed the consent form. I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risk, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary.

I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure._____ _____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ on _____,
Name of individual to be sterilized *Date of sterilization*

I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is a least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure. (Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery

☐ Individual's expected date of delivery:

☐ Emergency abdominal surgery:
(describe circumstances):

_____ Date: _____
Physician *Month/Day/Year*

ATTACH THE PROPERLY COMPLETED FORM TO MEDICAID CLAIMS RELATIVE TO STERILIZATIONS.

HYSTERECTOMY

The Federal regulation for hysterectomy requires that the recipient has been informed that the hysterectomy will render the individual permanently incapable of reproducing. The recipient must sign a statement acknowledging receipt of infertility information prior to surgery. Most hospital operative permits **DO NOT** meet the federal requirements for hysterectomy information. The Acknowledgment of Information form meets the requirements.

SPECIAL CONSIDERATIONS

If the woman was sterile prior to the hysterectomy she must sign the Acknowledgment of Information form, or the physician may write a statement that the recipient was sterile prior to the hysterectomy and the reason for the sterility. The statement must be signed and dated by the physician and the statement must be attached to the claim.

When a recipient requires a hysterectomy due to a life threatening emergency, and the physician determines that prior acknowledgment is not possible the physician must certify in writing that the hysterectomy was performed under a life-threatening emergency in which he or she determined prior acknowledgment was not possible. The physician must also include a description of the nature of the emergency. This statement, signed and dated by the physician, must be attached to the claim.

NOTE: DO NOT USE A STERILIZATION CONSENT FORM FOR A HYSTERECTOMY.

INTERPRETER'S STATEMENT

This section must be completed whenever the recipient cannot fully understand or speak English and must contain:

1. Name of the recipient's native language.
2. Signature of the interpreter and the date the information was provided.

DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES

ACKNOWLEDGEMENT OF INFORMATION FOR HYSTERECTOMY

Prior to having a hysterectomy, I understand/understood and fully acknowledge that the surgical procedure of hysterectomy renders me permanently sterile.

_____ _____

Signature Date

The Medicaid recipient must sign and date the Acknowledgment of Information form prior to Medicaid payment.

If an interpreter is provided to assist the individual on whom the hysterectomy is being performed:

INTERPRETER'S STATEMENT

I have translated the information and advice presented orally to the individual who is receiving a hysterectomy by the person obtaining this consent. I have also read to her, the consent form in language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

_____ _____

Interpreter Date

The Medicaid recipient must sign and date the Acknowledge of Information form prior to Medicaid payment.

DSS-Medical Services
hysterectomy form

NON-COVERED STERILIZATION AND HYSTERECTOMY SERVICES

The Medical Assistance program does not reimburse for the following:

1. Hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing;
2. Sterilization of a mentally incompetent individual;
3. Sterilization of an institutionalized individual;
4. Sterilization of an individual who has not reached his or her 21st birthday when the sterilization consent form is signed;
5. Sterilization or hysterectomy when the consent form is not completed, is not accurate, or is not legible; or
6. When the consent form or Acknowledgment of Information was signed more than 180 days prior to surgery.

CHAPTER III
HOSPICE PROVIDER COVERED SERVICES AND REIMBURSEMENT

South Dakota Medical Assistance Hospice Care Services

ABOUT HOSPICE

Hospice is an optional benefit that South Dakota has chosen to provide under Medical Assistance program. Hospice provides health care and support services to a terminally ill Medical Assistance recipient's or dually eligible recipient's and to the recipient's family. Recognizing the impending death, hospice care is an approach to treatment focusing on palliative rather than curative care. Hospice care includes attending to the emotional, spiritual, social and medical needs of the terminally ill recipient and the family. The hospice provider seeks to help the recipient and the family to come to terms with the terminal condition and help the recipient live the remaining days of life as comfortably, functionally and normally as possible.

PROVIDERS

A hospice may enroll as a Medical Assistance provider if licensed as a hospice provider by the Department of Health, meets Medicare conditions of participation and has an approved Medical Assistance provider agreement. Hospice provided to dually eligible recipients must be provided first in accordance with Medicare policies, rules, regulations and guidelines and second by the policies set forth in the State Medical Assistance Program Manual.

HOSPICE CARE ELIGIBILITY REQUIREMENTS

- A recipient must be certified as terminally ill to be eligible for coverage of hospice care. Hospice care may continue until a recipient is no longer certified as terminally ill or until the recipient or a representative revokes the election of hospice;
- A recipient may live in a home in the community or in a long-term care facility while receiving hospice services; and
- A dually eligible recipient must elect or revoke hospice care simultaneously under both the Medicare and the Medical Assistance programs.

Physician Certification

A written certification statement, signed by the medical director of the hospice or a physician member of the hospice interdisciplinary group and the recipient's attending physician should be obtained within two calendar days after hospice care is initiated. If the hospice does not obtain a written certification within two calendar days after hospice care is initiated, a verbal certification must be obtained within the two calendar days and a written certification must then be obtained no later than 8 days after care is initiated. If the certification requirements are not met, no payment can be made for hospice care provided prior to the date of any subsequent certification.

The certification statement must include a statement indicating the recipient's medical prognosis is a life expectancy of six months or less.

Election of Hospice Care

A recipient who is eligible for hospice care and who wishes to elect hospice care must sign an election statement. The election statement must include:

1. The name of the hospice providing care.
2. An acknowledgment that the recipient understands that hospice provides palliative, not curative care for the terminal illness.
3. An acknowledgment that the recipient waives all rights to Medical Assistance program payments for the duration of the election of hospice care for the following services:
    a. Hospice care provided by a hospice other than the hospice designated in (1) unless the care is provided under arrangement made by the designated hospice.
    b. Any Medical Assistance services related to the treatment of the terminal condition for which hospice care was elected; a related condition; or equivalent to hospice care except for services:
        - Provided directly or under arrangement by the designated hospice.
        - Provided by the recipient's attending physician if the physician is not an employee of or receiving compensation from the designated hospice.
        - Provided as room and board by a nursing facility or ICF/MR if the recipient is a resident of the facility.
4. The effective date of the election.
5. The signature of the recipient.

A legal representative of the recipient may act on behalf of the recipient in all matters pertaining to hospice care.

Revocation of Election of Hospice Care

A recipient may revoke the election of hospice care at any time by signing and dating a revocation statement that indicates the effective date of the revocation of hospice care. The effective date of the revocation must be on or after the date the form is signed. After revoking the election, a recipient may receive any of the Medical Assistance Program benefits they waived by choosing hospice care. A recipient may elect hospice again at any time if they are eligible for hospice care benefits.

Change of Designated Hospice Provider

A recipient may change the designation of the hospice provider from which the recipient chooses to receive care. A change of the designated hospice provider is not a revocation of the election. The recipient must sign a statement indicating the name of the hospice provider from which the recipient was receiving care, the name of the newly designated hospice provider and the effective date of the change. A copy of the statement must be maintained by both hospice providers.

Notification to the Department

A statement of certification, election, or revocation of election should be sent to the Medical Assistance program within two working days after the hospice provider obtains the signed statement from the recipient. Payment for hospice services will not be made until the appropriate documentation has been received by the Medical Assistance program.

Each hospice provider is to design and print its own statements of certification, election and revocation of election. For recipients dually eligible for Medicare and Medical Assistance, the statements used for Medicare may be used if appropriate references to the Medical Assistance program are included; for example, an election form should include a statement acknowledging the recipient waives Medical Assistance as well as Medicare benefits.

Developing a Plan of Care

An interdisciplinary team must assess a recipient's needs and develop a written plan of care before services can be provided. Services provided by the hospice must be consistent with the plan of care and must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

At least two members of the interdisciplinary team must be involved in the development of the initial plan of care, and one of these individuals must be a nurse or physician. The other members of the interdisciplinary team must review and provide input to the plan of care within two working days following the day of assessment.

Covered Services

The hospice must provide the services listed. Core services must routinely be provided directly by hospice employees. The hospice may contract for supplemental services provided during periods of peak patient load or for extraordinary circumstances. All services must be performed by appropriately qualified personnel.

Core Services Include:

1. Nursing services provided by or under the supervision of a registered nurse;
2. Social services provided by a social worker under the direction of a physician;
3. Services performed by a physician, dentist, optometrist, or chiropractor; and
4. Counseling services provided to the recipient and family member or other persons caring for the recipient at the recipient's home. Counseling, including dietary counseling, may be provided to train the recipient's family or caregiver to provide care and help the recipient, family members and caregivers adjust to the recipient's approaching death.

Supplemental Services Include:

1. Inpatient hospice care including procedures necessary for pain control or acute or chronic symptom management;
2. Inpatient respite care;

3. Medical equipment, supplies and drugs. Medical equipment including self help and personal comfort items related to the palliation or management of the recipient's terminal illness must be provided by the hospice for use in the recipient's home. Medical supplies include supplies specified in the written plan of care. Drugs include those used to relieve pain and control symptoms for the recipient's terminal illness;
4. Home health aide services and homemaker services which include personal care services and household services, such as changing a bed, light cleaning and laundering, necessary to maintain a safe and sanitary environment in areas of the home used by the recipient. Aide services must be provided under the supervision of a registered nurse; and
5. Physical therapy, occupational therapy, speech, and language pathology services provided for symptom control or to maintain activities of daily living and basic functional skills.

Payment for Hospice Services

The hospice provider is paid at one of four predetermined rates for each day a recipient is under the care of the hospice. The four rates exclude payment for physician services that are paid separately under the physician's individual provider agreement. The Medical Assistance program uses the rates established by Medicare for payment of Part A hospice benefits to pay the Medical Assistance program hospice services on a prospective basis.

The hospice provider is paid an amount applicable to the type and intensity of services provided each day to the recipient. The four levels of care into which each day of care is classified are:

Routine Home Care This level of care is used for each day the recipient is under the care of the hospice and the recipient is not classified at another level of care. This level of care is paid without regard to the volume or intensity of services provided.

Continuous Home Care This level of care is used for each day the recipient receives nursing services on a continuous basis during a period of crisis in the recipient's home. The hospice is paid an hourly rate for every hour of continuous home care furnished up to a maximum of 24 hours a day.

Inpatient Respite Care This level of care is for each day a recipient is in an inpatient facility and receiving respite care. Payment for inpatient respite care is limited to 5 consecutive days beginning with the day of admission but excluding the day of discharge. Any inpatient respite care days in excess of 5 consecutive days must be billed as routine home care. Inpatient respite care may not be paid when a recipient resides in a long-term care facility.

General Inpatient Care This level of care is for each day the recipient receives inpatient hospice care in an inpatient facility for control of pain or management of acute or chronic symptoms that cannot be managed in the home. The day of admission to the facility is general inpatient care and the day of discharge is not general inpatient care, unless the recipient is discharged deceased. Payment for general inpatient care may not be made to a long-term care facility when that facility is considered the recipient's home.

Payments for inpatient care days will be limited according to the number of inpatient care days furnished to medical assistance recipients by the hospice in a year. The maximum number of payable inpatient respite and general inpatient days may not exceed twenty percent of the total number of hospice care days provided to all medical assistance recipients by the hospice. If the maximum number of days exceeds twenty percent of total days, an adjustment will be made to pay the excess days at the routine home care rate and the difference will be recovered from the hospice provider. The limitation on inpatient care days does not apply to recipients diagnosed with acquired immunodeficiency syndrome (AIDS).

Payment for Physician Services

The daily rates paid for hospice care include payment for the administrative and general supervisory activities performed by the medical director or a physician member of the interdisciplinary team. These activities include participation in establishment of care plans, supervision of care and services, periodic review, updating of care plans, and establishment of governing policies. The cost of these activities may not be billed separately.

The hospice may be paid at the current Medicaid rate for physician services provided for purposes other than those listed above if the physician is an employee of the hospice or provides services under arrangement with the hospice. Payment is not available for donated physician services.

Payment may be made for personal professional services provided by a recipient's attending physician, if the physician is not an employee of the hospice, not providing services under arrangement with the hospice, or does not volunteer services to the hospice. Costs for services other than personal professional services, such as lab or x-ray, may not be included on the attending physician's bill and may not be billed separately.

Room and Board Payment for Recipient in Long-Term Care Facility

When hospice care is furnished to a recipient residing in a long-term care facility, payment to the long-term care facility by Medical Assistance is no longer available and the hospice is responsible for paying the room and board furnished by the long-term care facility. A room and board payment equal to 95% of the Medical Assistance program rate payable to the long-term care facility at the time the services are provided will be made to the hospice. The hospice may not negotiate a room and board rate with the long-term care facility with the exception of payment for private room accommodations. No additional payment will be made to the hospice for negotiated private room rates. No retroactive adjustments are available for charges in the Medical Assistance program rate made subsequent to the payment of room and board. Adjustments may be made to correct errors in billing.

If a recipient has a recipient liability, the amount will be shown on a remittance advice. The hospice is responsible for collection of this amount from the recipient. The hospice may make arrangement with the long-term care facility to collect the recipient liability. The Medical Assistance program will not reimburse the hospice for any uncollected recipient liability.

Billing Procedures

A hospice claim must be submitted for all individuals electing hospice who are Medical Assistance eligible even if no payment is due from the Medical Assistance program and payment is made entirely by Medicare, insurance or other payment source.

Hospice services and room and board charges must be billed on a UB-04. If billing more than one level of care, a separate bill may be prepared each time the level of care changes during the hospice's billing period. A billing period is defined as a calendar month or a portion of a calendar month**.**

CHAPTER IV
BILLING INSTRUCTIONS

INPATIENT/OUTPATIENT, USING THE UNIFORM BILLING CLAIM FORM CMS 1450 (UB-04).

These instructions are a supplement or clarification of your UB-04 Manual received from the South Dakota Hospital Association.

The hospital claim has been designed so that either inpatient or outpatient services for one patient may be billed on the claim. At no time may both inpatient and outpatient services be billed on the same claim. If a patient receives both outpatient and inpatient services on the same day, all hospital services must be billed as inpatient services.

The South Dakota Association of Healthcare Organization is the clearinghouse for UB-04 billing manuals and/or instructions. Their address is as follows:

South Dakota Association of Healthcare Organization (SDAHO)
3708 Brooks Place, Suite 1
Sioux Falls, SD 57104
Telephone (605) 361-2281

Claim forms are not supplied by The South Dakota Medical Assistance Program but must meet the requirements of the South Dakota UB-04 committee.
The Hospital claim is a multiple-part form. Submit the original payer copy to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

The provider is responsible for the proper postage**.**

CODES
The codes specified for hospital use in a Medicaid Management Information System (MMIS) by the Department of Health and Human Services (HHS), CMS are:

For Diagnosis	ICD-9-CM, Internal Classifications of Diseases 9th Edition, Clinical Medicine
For Procedures	Same as diagnosis
Outpatient Laboratory	HCPCS or CPT/4
Outpatient Surgical Procedures	HCPCS or CPT/4

ICD-9-CM code books may be purchased from:

Medicode
5225 Weley Post Way, Ste 500
Salt Lake City, UT 84116-2889

SUBMISSION

The Medical Assistance program must receive a provider's completed claim form within 12 months following the month the services were provided, unless third party liability insurance is involved or initial retroactive eligibility is determined.

A provider may only submit a claim for services he knows or should have known are covered by the Medical Assistance program.

A claim must be submitted at the provider's usual and customary charge for this service on the date the service was provided.

The name which appears on the remittance advice indicates the provider name which the Medical Assistance program associates with the assigned provider number. This name must correspond with the name submitted on claim forms.

HOW TO COMPLETE THE CMS 1450 (UB-04) CLAIM FORM

Failure to properly complete **MANDATORY** requirements will be cause for non-processing or denial of the claim by the Medical Assistance program**.**

The following information is a locator by locator explanation of how to prepare the CMS 1450 (UB-92) claim form.

LOCATOR 1 **PROVIDER NAME, ADDRESS & TELEPHONE NUMBER**
Enter the name of the provider submitting the bill, address, city, state, zip code, and telephone **(MANDATORY)** Fax and Country (optional).

LOCATOR 2 PAY-TO NAME AND ADDRESS
Enter the pay-to name, address, city, state, and zip code.

LOCATOR 3 PATIENT CONTROL NUMBER
Patient's unique alpha-numeric number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment.

LOCATOR 4 **TYPE OF BILL (MANDATORY)**
Enter the code indicating the specific type of bill. (See below the only acceptable codes under the South Dakota Medical Assistance Program.)

HOSPITAL INPATIENT

111 Hospital Inpatient, Admission through Discharge
117 Hospital Inpatient, Replacement
118 Hospital Inpatient, Void

Long Term Care

211 Admission through Discharge
217 Replacement
218 Void

HOSPITAL OUTPATIENT

131 Hospital Outpatient/Hospice, Admission through Discharge
137 Hospital Outpatient, Replacement
138 Hospital Outpatient, Void

OUTPATIENT HOSPITAL SURGICAL PROCEDURES

831 Outpatient Hospital Surgical Procedures, Admission through Discharge
837 Outpatient Hospital Surgical Procedures, Replacement
838 Outpatient Hospital Surgical Procedures, Void

LOCATOR 5 FEDERAL TAX NUMBER

The number assigned to the provider by the federal government for tax reporting purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).

LOCATOR 6 **STATEMENT COVERS PERIOD (MANDATORY)**

Enter the beginning and ending service dates of the period included on this claim.

LOCATOR 7 UNLABELD FIELD

Leave Blank

LOCATOR 8 **PATIENT I.D. NUMBER AND NAME (MANDATORY)**

Enter in 8a the patient's Medicaid I.D. number from the patient's South Dakota Medical Assistance card. Enter in 8b the patient's full name.

LOCATOR 9 PATIENT ADDRESS

Enter in 9a the patient's address, 9b city, 9c state, 9d zip code, and 9e country.

LOCATOR 10 PATIENT BIRTHDATE

Enter patient's birthdate.

LOCATOR 11 PATIENT SEX

Enter patient's sex.

LOCATOR 12 **ADMISSION/START OF CARE DATE (MANDATORY)**

Enter the date the patient was admitted for inpatient services.
Enter the date of service for an outpatient claim.

LOCATOR 13 **ADMISSION HOUR (MANDATORY)**

Enter the hour during which the patient was admitted for inpatient or outpatient care.

LOCATOR 14 **TYPE OF ADMISSION (MANDATORY)**

Enter the code indicating the priority of this admission. (See below)
Admission Type 1 - Indicates the Medical Assistance program recipient was treated for a "true emergency". Block 76, Block 77, Block 78, and Block 79 would be bypassed and the claim would be adjudicated.

Admission Type 2 - Indicates the Medical Assistance program recipient was treated for "urgent" care. The Medical Assistance program will reimburse the emergency room (450 revenue code) only. Any treatment (ancillary code(s)) is the responsibility of the Medical Assistance program managed care recipient. Unless treatment has been prior referred or authorized by the recipient's PCP, Block 78 or Block 79 must contain the recipient's PCP SEVEN DIGIT Medical Assistance program PROVIDER IDENTIFICATION NUMBER.

Admission Type 3 - Indicates the Medical Assistance program recipient was treated for elective care. If there was an actual referral from the Primary Care Provider (PCP) then Block 78 or Block 79 must contain the recipient's PCP SEVEN DIGIT SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM PROVIDER IDENTIFICATION NUMBER.

LOCATOR 15 **SOURCE OF ADMISSION (MANDATORY) (INPATIENT ONLY)**

For Indian Health Services contract or 638 contract care, enter a "0". When a "0" is entered, a managed care referral is not needed.

LOCATOR 16 **DISCHARGE HOUR (MANDATORY)**

Enter the hour the patient was discharged from inpatient care.

LOCATOR 17 **PATIENT STATUS (MANDATORY) (INPATIENT ONLY)**

Enter the code indicating the patient status as of the ending service date of the period covered on this bill. (See below the definitions of the only acceptable codes under the South Dakota Medical Assistance Program.)

01 Discharges home or self-care (routine discharge) including discharges to foster homes, group homes, halfway houses, and supervised personal care facilities as well as private residences.
02 Discharges/transfers/referrals to another short term general hospital such as acute care hospitals, public health service hospitals, neonatal units, etc.
03 Discharges/transfers to skilled nursing facilities (SNF) including swing beds, sub acute care centers and Medicare nursing facilities as well as skilled nursing homes.

04 Discharges/transfers to intermediate care facilities (ICF) including adjustment training centers, Redfield State Hospital, as well as regular intermediate care nursing homes.
05 Discharges/transfers/referrals to another type of institution such as rehabilitation hospitals or units, military or VA hospitals, etc.
06 Discharges/transfers to home under the care of an organized home health service organization.
07 Left against medical advice.
08 Discharges/transfers to home under care of a home IV provider.
10 Discharges/transfers/referrals to mental health facilities such as freestanding psychiatric hospitals, psychiatric units, etc.
20 Expired
30 Still an inpatient. This is an invalid code except for DRG-exempt Hospital/Unit claims and Nursing Home.

INVALID CODES:
09, 11-19, 21-29, 31-99 these are all invalid codes which should not be used for inpatient hospital claims.

LOCATOR 18-28 CONDITION CODES
A code(s) used to identify conditions relating to this bill that may affect payer processing.

LOCATOR 29 ACCIDENT STATE
The two letter state abbreviation the accident occurred in. (if applicable)

LOCATOR 30 UNLABELED FIELD
Leave Blank

LOCATOR 31-34 OCCURRENCE CODES AND DATES
The code and associated date defining a significant event relating to this bill that may affect payer processing.

LOCATOR 35-36 OCCURRENCE SPAN CODE AND DATES
A code and the related dates that identify an event that relates to the payment of the claim.

LOCATOR 37 UNLABELED FIELD
Leave Blank

LOCATOR 38 RESPONSIBLE PARTY NAME AND ADDRESS
The name and address of the party responsible for the bill.

LOCATOR 39-41 VALUE CODES AND AMOUNTS
A code structure to relate amounts or values to identified data elements necessary to process this claim as qualified by the payer organization.

LOCATOR 42 **REVENUE CODE (MANDATORY)**
Enter the code which identifies the specific accommodation, ancillary service or billing calculation.

LOCATOR 43 REVENUE DESCRIPTION
A narrative description of the related revenue categories included on this bill. Abbreviations may be used.

LOCATOR 44 **HCPCS/RATES (MANDATORY)**
Enter the accommodation rate for inpatient bills and the Healthcare Common Procedure Coding Systems (HCPCS) applicable to ancillary service and outpatient bills.

LOCATOR 45 SERVICE DATE
The date the indicated service was provided.

LOCATOR 46 **UNITS OF SERVICE (MANDATORY)**
Enter quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, or renal dialysis treatments**.**

LOCATOR 47 **TOTAL CHARGES (MANDATORY)**
Enter total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period.
Total charges include both covered and non-covered charges.

LOCATOR 48 **NON - COVERED CHARGES (MANDATORY)**
Enter the amount to reflect non-covered charges for the primary payer pertaining to the related revenue code.

LOCATOR 49 UNLABELED FIELD
Leave blank.

LOCATOR 50 **PAYER IDENTIFICATION (MANDATORY)**
If the Medical Assistance program is the only payer, enter "Medicaid". If other payers exist, Medicaid is always payer of last resort; for Part B Medicare Only - Submit a Medical Assistance program claim using CMS 1450 (UB-04) claim form for the total charges and enter in locator 50A and 50B "Payer" as follows:

A)	Medicare	001
B)	Medicaid	999
C)	TPL (Third Party Liability)	141

LOCATOR 51 HEALTH PLAN ID

Enter the providers N.P.I number, 7-digit Medical Assistance Program Provider Identification Number, and/or Proprietary Number for the service being billed.

LOCATOR 52 RELEASE OF INFORMATION CERTIFICATION INDICATOR

A code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

LOCATOR 53 ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR

A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.

LOCATOR 54 **PRIOR PAYMENTS – PAYERS (MANDATORY)**

Enter the amount the hospital has received toward payment of the bill prior to the billing date by the indicated payer. **Do not put recipient cost share in this field.**

LOCATOR 55 ESTIMATED AMOUNT DUE

The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).

LOCATOR 56 **NATIONAL PROVIDER NUMBER (NPI) (MANDATORY)**

Enter the provider's National Provider Identification (NPI) number.

LOCATOR 57 OTHER PROVIDER ID NUMBER

Enter the providers 7-digit Medical Assistance Program Provider Identification Number, which was assigned by the South Dakota Medical Assistance Program and/or Proprietary Number.

LOCATOR 58 **INSURED'S NAME (MANDATORY)**

Enter the insured's last name, first name, and middle initial. Name must correspond with the name on the South Dakota Medical Assistance Program ID card. If the patient is covered by insurance other than South Dakota Medical Assistance Program, enter the name of the individual in whose name the insurance is carried.

LOCATOR 59 PATIENT'S RELATIONSHIP TO INSURED

A code indicating the relationship of the patient to the identified insured.

LOCATOR 60 **INSURED'S UNIQUE ID NUMBER (MANDATORY)**
The recipient identification number is the 9-digit number found on the Medical Assistance program Identification Card. The 3-digit generation number located behind the 9-digit recipient number is **not** part of the recipients ID number and should **not** be entered on the claim.

LOCATOR 61 INSURED GROUP NAME **(MANDATORY IF APPLICABLE)**
When the Medical Assistance program is secondary payer, enter the insured group name of primary payer.

LOCATOR 62 INSURANCE GROUP NUMBER **(MANDATORY IF APPLICABLE)**
When the South Dakota Medical Assistance Program is secondary payer, enter the insured group number of the primary payer.

LOCATOR 63 TREATMENT AUTHORIZATION CODE
Required, if services must be prior authorized. Enter prior authorization number here.
If prior authorization is not required leave blank.

LOCATOR 64 DOCUMENT CONTROL NUMBER
Leave Blank. Reserved for Office Use.

LOCATOR 65 EMPLOYER NAME
The name of the employer that might or does provide health care coverage for the insured individual identified in Form Locator 58.

LOCATOR 66 DIAGNOSIS AND PROCEDURE CODE QUALIFIER (ICD VERSION)
The qualifier code that denotes the version of International Classification of Diseases (ICD) reported.

LOCATOR 67 **PRINCIPAL AND OTHER DIAGNOSIS CODES (MANDATORY)**
Enter the ICD-9-CM code for the principal diagnosis in locater 67. Enter the other diagnosis codes other than the principal diagnosis in form locators A-Q.

The definition of Principal Diagnosis Code is: The ICD-9-CM codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

The definition of Other Diagnosis Codes is: The ICD-9-CM diagnoses codes corresponding to additional conditions that co-exist at the time of admission, and/or develop subsequently, and which have an affect on the treatment received or the length of stay.

LOCATOR 68 UNLABELED FIELD
Leave blank.

LOCATOR 69 **ADMITTING DIAGNOSIS (MANDATORY) (INPATIENT ONLY)**
Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician**.**

LOCATOR 70 PATIENT'S REASON FOR VISIT
The ICD-CM diagnosis codes describing the patients' reason for visit at the time of outpatient registration.

LOCATOR 71 PROSPECTIVE PAYMENT SYSTEM (PPS) CODE
The PPS code assigned to the claim to identify the DRG based on the grouper.

LOCATOR 72 EXTERNAL CAUSE OF INJURY CODE (E-CODE)
The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.

LOCATOR 73 UNLABELED FIELD
Leave blank.

LOCATOR 74 **PRINCIPAL AND OTHER PROCEDURE CODES AND DATE (MANDATORY)**
Enter the ICD-9-CM code identifying the principal surgical or obstetrical procedure in locator 74. Enter other procedure codes in locators A-E. Date is required, if applicable.

LOCATOR 75 UNLABELED FIELD
Leave blank.

LOCATOR 76 ATTENDING PHYSICIAN ID
Enter the NPI and name of the individual who has overall responsibility for the patient's care and treatment reported in this claim.
Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 77 OPERATING PHYSICIAN ID
Enter the NPI and name of the individual with the primary responsibility for performing the surgical procedures reported in this claim.
Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 78-79 **OTHER PHYSICIAN ID (MANDATORY)**
(MANAGED CARE RECIPIENTS ONLY)
Enter primary qualifier, NPI, and name of the referring, other operating, or rendering physician.
Primary qualifiers: **DN- Referring Provider**, ZZ- Other Operating Physician, or 82- Rendering Physician
Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 80 REMARKS
Enter former reference number for adjustments and voids.

LOCATOR 81 CODE-CODE FIELD
To report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

SPECIAL BILLING INSTRUCTIONS

INPATIENT SERVICES - OUTPATIENT SERVICES
Separate claim forms are required for each patient/recipient receiving services, i.e. mother and baby (babies).

OUTPATIENT LABORATORY SERVICES
For an outpatient laboratory test, the laboratory that actually performed the test must submit the claim for the test.

Laboratory services must be itemized and entered in Locators 42, 43, 44, 46, and 47 as follows:

Rev. Co.	Description	HCPS/ Rates	Serv Date	Serv Units	Total Charges	Non-Covered Charges	Nat'l
42	43	44	45	46	47	48	49
300	Urinalysis	81000		1	10.00		

HCPC coding is a mandatory entry in locator 44. Reimbursement for laboratory procedures is based on the Healthcare Common Procedure Coding System (HCPCS).

INPATIENT LABORATORY SERVICES
For an inpatient laboratory test, either the hospital or the outside laboratory may submit the claim for the test.

WHEN A RECIPIENT LOOSES ELIGIBLITY DURING AN INPATIENT STAY
For recipients who are not eligible the entire length of stay, a two (2) paper claim and special request for review should be submitted for only the dates of service that the recipient is eligible. Reimbursement will be prorated based on the individual's eligibility.

COST SHARE

Cost sharing for hospital services not billed as emergencies is five percent of the total outpatient allowable charge, up to a maximum of $50.00. Charges for laboratory services are excluded when computing the amount of the cost share.

AMBULATORY SURGERY CLINICS

Ambulatory Surgery Clinics must use the CMS 1450 (UB-92) claim form. The Revenue codes must be assigned for services provided based on the South Dakota, CMS 1450 (UB-92) Manual examples:

36X	Operating Room Services	51X	Clinic
45X	Emergency Room	75X	Gastro Intestinal Services
49X	Ambulatory Surgical Care	79X	Lithotripsy

REPLACEMENT AND VOID CLAIMS

If an error has been discovered when payment has been received and correction is needed, take the following action:

VOID REQUEST

A void request asks the Medical Assistance program to take back all the money paid for a claim. Every line is reversed. A paid line has the payment taken back from it. A denied line remains denied. A pending line is denied. The transaction is shown on your remittance advice and the money taken back is deducted from any payment that may be due to you.

To submit a void request, follow the steps below:

- Make a copy of your paid claim.
- Enter the correct Type of Bill in form locator 4.

Claim Type	Replacement	Void
Inpatient	117	118
Outpatient	137	138
Long Term Care	217	218
Ambulatory Surgery	837	838

- In form locator 80, enter the claim reference number that Medical Assistance assigned to the original claim.
- Highlight form locator 80.
- Send the void request to the same address you have always used.
- Keep a copy of your request for your files.

If the original claim reference number is not shown on the void request, it will not be processed, and will appear on your remittance advice as an error.

Once a claim has been voided, it cannot be reversed and repaid. You must submit a new claim.

REPLACEMENT REQUEST

A replacement request consists of two steps. First, a credit adjustment, or void, is generated by the claims payment system for each line on the original claim, and processed. This part of the transaction works as described in void processing above. Then, the corrections you supply are entered and the entire claim is processed. A paid line can be increased or decreased. A denied line remains denied, and a pended line is also denied. The replacement claim may include more or fewer lines than the original. Additionally, the changes may be informational only. The transaction is shown on the remittance advice and changes in payment are added to or deducted from any payment that may be due.

To submit a replacement request, follow the steps below:

- Make a copy of the paid claim.
- Enter the correct Type of Bill form locator 4

Claim Type	Replacement	Void
Inpatient	117	118
Out patient	137	138
Long Term Care	217	218
Ambulatory Surgery	837	838

- In form locator 80, enter the claim reference number that South Dakota Medical Assistance assigned to the original claim.
- Highlight form locator 80.
- Indicate corrections to the claim by striking through incorrect information and entering corrections. Use correction fluid or tape to remove incorrect information and replace with correct information.
- Highlight all the corrections entered.
- Do not attach additional separate pages or use post-it notes. These may become separated from the request and delay processing.
- Send the replacement request to the same address you have always used.
- Keep a copy of the request on file.

An original claim can be replaced only once. You may, however, submit a void or replacement request for a previously completed replacement. In this case, enter the appropriate Type of Bill code (see above) in form locator 4 and enter the claim reference number of the replacement claim in form locator 80. Highlight form locator 80, enter and highlight any corrections, as described above, and submit your request.

The Medical Assistance claims payment system links the original claim with subsequent replacement and/or void requests, to ensure that any transaction is only replaced or voided once.

BILLING MEDICARE

When an individual is a Medicare and Medical Assistance recipient, Medicare must be billed by the provider as the primary carrier.

INPATIENT/OUTPATIENT MEDICARE CROSSOVER CLAIMS, USING THE UNIFORM BILLING CLAIM FORM CMS 1450 (UB-04).

These instructions are a supplement to the UB-04 Manual received from the South Dakota Hospital Association.

The hospital claim has been designed so that either inpatient or outpatient services for one patient may be billed on the claim. At no time may both inpatient and outpatient services be billed on the same claim.

The South Dakota Association of Healthcare Organization is the clearinghouse for UB-04 billing manuals and/or instructions. Their address is as follows:

South Dakota Association of Healthcare Organization (SDAHO)
3708 Brooks Place, Suite 1
Sioux Falls, SD 57104
Telephone (605) 361-2281

Claim forms are not supplied by the Division of Medical Services but must meet the requirements of the South Dakota UB-04 committee.

The Hospital claim is a multiple-part form. Submit the original payer copy to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

The provider is responsible for the proper postage.

CODES

The codes specified for hospital use in a Medicaid Management Information System (MMIS) by the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) are:

For Diagnosis:	ICD-9-CM, Internal Classifications of Diseases 9th Edition, Clinical Medicine
For Procedures:	Same as diagnosis
Outpatient Laboratory:	HCPCS or CPT/4
Outpatient Surgical Procedures:	HCPCS or CPT/4

ICD-9-CM code books may be purchased in hard cover or paperback from:

Medicode
5225 Weley Post Way, Ste 500
Salt Lake City, UT 84116-2889

SUBMISSION

The department must receive a provider's completed claim form within 12 months following the month the services were provided, unless third party liability insurance is involved or initial retroactive eligibility is determined.

A provider may only submit a claim for services he knows or should have known are covered by the Medical Assistance program.

The name, which appears on the remittance advice, indicates the provider name, which the DSS associates with the assigned provider number. This name must correspond with the name submitted on claim forms.

HOW TO COMPLETE THE CMS 1450 (UB-04) MEDICARE CROSSOVER CLAIM FORM

Failure to properly complete **MANDATORY** requirements will be cause for non-processing or denial of the claim by the Medical Assistance program.

THE FOLLOWING IS A BLOCK BY BLOCK EXPLANATION OF HOW TO PREPARE THE MEDICARE CROSSOVER CLAIM ON THE CMS 1450 (UB04) CLAIM FORM.

LOCATOR 1 **PROVIDER NAME, ADDRESS & TELEPHONE NUMBER**
Enter the name of the provider submitting the bill, address, city, state, zip code, and telephone **(MANDATORY)** Fax and Country (optional).

LOCATOR 2 PAY-TO NAME AND ADDRESS
Enter the pay-to name, address, city, state, and zip code.

LOCATOR 3 PATIENT CONTROL NUMBER
Patient's unique alpha-numeric number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment.

LOCATOR 4 **TYPE OF BILL (MANDATORY)**
Enter the code indicating the specific type of bill. (See below the only acceptable codes under the Medical Assistance program.)

HOSPITAL INPATIENT
111 Hospital Inpatient, Admission through Discharge
117 Hospital Inpatient, Replacement
118 Hospital Inpatient, Void

Long Term Care
211 Admission through Discharge
217 Replacement
218 Void

HOSPITAL OUTPATIENT
131 Hospital Outpatient/Hospice, Admission through Discharge
137 Hospital Outpatient, Replacement
138 Hospital Outpatient, Void

OUTPATIENT HOSPITAL SURGICAL PROCEDURES

831 Outpatient Hospital Surgical Procedures, Admission through Discharge
837 Outpatient Hospital Surgical Procedures, Replacement
838 Outpatient Hospital Surgical Procedures, Void

LOCATOR 5 FEDERAL TAX NUMBER

The number assigned to the provider by the federal government for tax reporting purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).

LOCATOR 6 **STATEMENT COVERS PERIOD (MANDATORY)**

Enter the beginning and ending service dates of the period included on this bill.

LOCATOR 7 UNLABELD FIELD

Leave Blank

LOCATOR 8 **PATIENT I.D. NUMBER AND NAME (MANDATORY)**

Enter in 8a the patient's Medicaid I.D. number from the patient's Medical Assistance card. Enter in 8b the patient's full name.

LOCATOR 9 PATIENT ADDRESS

Enter in 9a the patient's address, 9b city, 9c state, 9d zip code, and 9e country.

LOCATOR 10 PATIENT BIRTHDATE

Enter patient's birthdate.

LOCATOR 11 PATIENT SEX

Enter patient's sex.

LOCATOR 12 **ADMISSION/START OF CARE DATE (MANDATORY)**

Enter the date the patient was admitted for inpatient services.
Enter the date of service for an outpatient claim.

LOCATOR 13 **ADMISSION HOUR (MANDATORY)**

Enter the hour during which the patient was admitted for inpatient or outpatient care.

LOCATOR 14 **TYPE OF ADMISSION (MANDATORY)**

Enter the code indicating the priority of this admission. (See below)
Admission Type 1 - Indicates the Medical Assistance recipient was treated for a "true emergency". Block 78, and Block 79 would be bypassed and the claim would be adjudicated.

Admission Type 2 - Indicates the Medical Assistance recipient was treated for "urgent" care. The Medical Assistance program will reimburse the emergency room (450 revenue code) only. Any treatment (ancillary code(s)) is the responsibility of the Medical Assistance program managed care recipient. Unless treatment has been prior referred or authorized by the recipient's PCP, Block 78 or Block 79 must contain the recipient's PCP SEVEN DIGIT Medical Assistance program PROVIDER IDENTIFICATION NUMBER.

Admission Type 3 - Indicates the Medical Assistance recipient was treated for elective care. If there was an actual referral from the Primary Care Provider (PCP) then Block 78 or Block 79 must contain the recipient's PCP SEVEN DIGIT MEDICAL ASSISTANCE PROGRAM PROVIDER IDENTIFICATION NUMBER.

LOCATOR 15 **SOURCE OF ADMISSION (MANDATORY) (INPATIENT ONLY)**
For Indian Health Services contract or 638 contract care, enter a "0". When a "0" is entered, a managed care referral is not needed.

LOCATOR 16 **DISCHARGE HOUR (MANDATORY)**
Enter the hour the patient was discharged from inpatient care.

LOCATOR 17 **PATIENT STATUS (MANDATORY) (INPATIENT ONLY)**
Enter the code indicating the patient status as of the ending service date of the period covered on this bill. (See below the definitions of the only acceptable codes under the Medical Assistance program.)

01 Discharges home or self-care (routine discharge) including discharges to foster homes, group homes, halfway houses, and supervised personal care facilities as well as private residences.
02 Discharges/transfers/referrals to another short term general hospital such as acute care hospitals, public health service hospitals, neonatal units, etc.
03 Discharges/transfers to skilled nursing facilities (SNF) including swing beds, sub acute care centers and Medicare nursing facilities as well as skilled nursing homes.
04 Discharges/transfers to intermediate care facilities (ICF) including adjustment training centers, Redfield State Hospital, as well as regular intermediate care nursing homes.
05 Discharges/transfers/referrals to another type of institution such as rehabilitation hospitals or units, military or VA hospitals, etc.
06 Discharges/transfers to home under the care of an organized home health service organization.
07 Left against medical advice.
08 Discharges/transfers to home under care of a home IV provider.

10 Discharges/transfers/referrals to mental health facilities such as freestanding psychiatric hospitals, psychiatric units, etc.
20 Expired
30 Still an inpatient. This is an invalid code except for DRG-exempt Hospital/Unit claims and Nursing Home.

INVALID CODES:
09, 11-19, 21-29, 31-99 these are all invalid codes which should not be used for inpatient hospital claims.

LOCATOR 18-28 CONDITION CODES
A code(s) used to identify conditions relating to this bill that may affect payer processing.

LOCATOR 29 ACCIDENT STATE
The two letter state abbreviation the accident occurred in. (if applicable)

LOCATOR 30 UNLABELED FIELD
Leave Blank

LOCATOR 31-34 OCCURRENCE CODES AND DATES
The code and associated date defining a significant event relating to this bill that may affect payer processing.

LOCATOR 35-36 OCCURRENCE SPAN CODE AND DATES
A code and the related dates that identify an event that relates to the payment of the claim.

LOCATOR 37 UNLABELED FIELD
Leave Blank

LOCATOR 38 RESPONSIBLE PARTY NAME AND ADDRESS
The name and address of the party responsible for the bill.

LOCATOR 39-41 **VALUE CODES AND AMOUNTS (MANDATORY)**
Enter in lines a, b, c, and/or d the report codes **06, 08, 09, 10,** and/or **11** and the appropriate co-insurance amount for each code.
Enter in lines a, b, c, and/or d the report code **A1** for the deductible Part A cash deductible amount only.

LOCATOR 42 **REVENUE CODE (MANDATORY)**
Enter the code which identifies the specific accommodation, ancillary service or billing calculation.

LOCATOR 43 REVENUE DESCRIPTION

A narrative description of the related revenue categories included on this bill. Abbreviations may be used.

LOCATOR 44 **HCPCS/RATES (MANDATORY)**
Enter the accommodation rate for inpatient bills and the CMS Common Procedure Coding Systems (HCPCS) applicable to ancillary service and outpatient bills.

LOCATOR 45 SERVICE DATE
The date the indicated service was provided.

LOCATOR 46 **UNITS OF SERVICE (MANDATORY)**
Enter quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, or renal dialysis treatments**.**

LOCATOR 47 **TOTAL CHARGES (MANDATORY)**
Enter total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period.
Total charges include both covered and non-covered charges.

LOCATOR 48 **NON - COVERED CHARGES (MANDATORY)**
Enter the amount to reflect non-covered charges for the primary payer pertaining to the related revenue code.

LOCATOR 49 UNLABELED FIELD
Leave blank.

LOCATOR 50 **PAYER IDENTIFICATION (MANDATORY)**
If The South Dakota Medical Assistance Program is the only payer, enter "Medicaid". If other payers exist, Medicaid is always payer of last resort; for Part B Medicare Only - Submit a Medical Assistance claim using CMS 1450 (UB-04) claim form for the total charges and enter in locator 50A and 50B "Payer" as follows:

A)	Medicare	001
B)	Medicaid	999
C)	TPL (Third Party Liability)	141

LOCATOR 51 HEALTH PLAN ID
Enter the providers NPI number, 7-digit Medical Assistance Program Provider Identification Number, and/or Proprietary Number for the service being billed.

LOCATOR 52 RELEASE OF INFORMATION CERTIFICATION INDICATOR
A code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

LOCATOR 53 ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR
A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.

LOCATOR 54 **PRIOR PAYMENTS – PAYERS (MANDATORY)**
Enter the amount the hospital has received toward payment of the bill prior to the billing date by the indicated payer. **Do not put recipient cost share in this field.**

LOCATOR 55 **ESTIMATED AMOUNT DUE (MANDATORY)**
The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).

LOCATOR 56 **NATIONAL PROVIDER NUMBER (NPI) (MANDATORY)**
Enter the provider's National Provider Identification (NPI) number.

LOCATOR 57 OTHER PROVIDER ID NUMBER
Enter the providers 7-digit Medical Assistance Program Provider Identification Number, which was assigned by the Medical Assistance program.

LOCATOR 58 **INSURED'S NAME (MANDATORY)**
Enter the insured's last name, first name, and middle initial. Name must correspond with the name on the South Dakota Medical Assistance Program ID card. If the patient is covered by insurance other than South Dakota Medical Assistance Program, enter the name of the individual in whose name the insurance is carried.

LOCATOR 59 PATIENT'S RELATIONSHIP TO INSURED
A code indicating the relationship of the patient to the identified insured.

LOCATOR 60 **INSURED'S UNIQUE ID NUMBER (MANDATORY)**
The recipient identification number is the 9-digit number found on the Medical Assistance Identification Card. The 3-digit generation number located behind the 9-digit recipient number is **not** part of the recipients ID number and should **not** be entered on the claim.

LOCATOR 61 INSURED GROUP NAME **(MANDATORY IF APPLICABLE)**
When the Medical Assistance program is the secondary payer, enter the insured group name of primary payer.

LOCATOR 62 INSURANCE GROUP NUMBER **(MANDATORY IF APPLICABLE)**
When Medical Assistance is secondary payer, enter the insured group number of the primary payer.

LOCATOR 63 TREATMENT AUTHORIZATION CODE
Required, if services must be prior authorized. Enter prior authorization number here.
If prior authorization is not required leave blank.

LOCATOR 64 DOCUMENT CONTROL NUMBER
Leave Blank. Reserved for Office Use.

LOCATOR 65 EMPLOYER NAME
The name of the employer that might or does provide health care coverage for the insured individual identified in Form Locator 58.

LOCATOR 66 DIAGNOSIS AND PROCEDURE CODE QUALIFIER (ICD VERSION)
The qualifier code that denotes the version of International Classification of Diseases (ICD) reported.

LOCATOR 67 **PRINCIPAL AND OTHER DIAGNOSIS CODES (MANDATORY)**
Enter the ICD-9-CM code for the principal diagnosis in locater 67. Enter the other diagnosis codes other than the principal diagnosis in form locators A-Q.

The definition of Principal Diagnosis Code is: The ICD-9-CM codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

The definition of Other Diagnosis Codes is: The ICD-9-CM diagnoses codes corresponding to additional conditions that co-exist at the time of admission, and/or develop subsequently, and which have an affect on the treatment received or the length of stay.

LOCATOR 68 UNLABELED FIELD
Leave blank.

LOCATOR 69 **ADMITTING DIAGNOSIS (MANDATORY) (INPATIENT ONLY)**
Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician**.**

LOCATOR 70 PATIENT'S REASON FOR VISIT
The ICD-CM diagnosis codes describing the patients' reason for visit at the time of outpatient registration.

LOCATOR 71 PROSPECTIVE PAYMENT SYSTEM (PPS) CODE
The PPS code assigned to the claim to identify the DRG based on the grouper.

LOCATOR 72 EXTERNAL CAUSE OF INJURY CODE (E-CODE)
The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.

LOCATOR 73 UNLABELED FIELD
Leave blank.

LOCATOR 74 **PRINCIPAL AND OTHER PROCEDURE CODES AND DATE (MANDATORY)**
Enter the ICD-9-CM code identifying the principal surgical or obstetrical procedure in locator 74. Enter other procedure codes in locators A-E. Date is required, if applicable.

LOCATOR 75 UNLABELED FIELD
Leave blank.

LOCATOR 76 ATTENDING PHYSICIAN ID
Enter the NPI and name of the individual who has overall responsibility for the patient's care and treatment reported in this claim.
Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 77 OPERATING PHYSICIAN ID
Enter the NPI and name of the individual with the primary responsibility for performing the surgical procedures reported in this claim.
Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 78-79 **OTHER PHYSICIAN ID (MANDATORY)**
(MANAGED CARE RECIPIENTS ONLY)
Enter primary qualifier, NPI, and name of the referring, other operating, or rendering physician.
Primary qualifiers: **DN- Referring Provider**, ZZ- Other Operating Physician, or 82- Rendering Physician
Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 80 REMARKS
Enter former reference number for adjustments and voids.

LOCATOR 81 CODE-CODE FIELD

To report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

MANDATORY: The provider MUST attach the Medicare Explanation of Benefits and any applicable third party Explanation of benefits to **EACH** claim form.

SPECIAL BILLING INSTRUCTIONS

INPATIENT SERVICES - OUTPATIENT SERVICES - LONG TERM CARE

Separate claim forms are required for each patient/recipient receiving services, i.e. mother and baby (babies).

REPLACEMENT AND VOID CLAIMS

If an error has been discovered when payment has been received and correction is needed, take the following action:

INPATIENT SERVICE AND LONG TERM CARE CLAIMS:

Type of bill 117 or 118 (Locator 4 - type of bill)

Type 117 "Replacement" - prepare a complete CMS 1450 (UB-04) claim form making corrections.

Type 118 "Void" - prepare a complete CMS 1450 (UB-04) claim form, or provide as much information as possible, stating in "Locator 84" the reason for voiding the claim. Previous payment will be deducted from current payments.

OUTPATIENT/SPECIAL FACILITY: Type of bill 137/837 or 138/838 (Locator 4 - type of bill).

Type 137/837 "Replacement" - prepare a complete CMS 1450 (UB-04) claim form making corrections.

Type 138/838 "Void" - prepare a complete CMS 1450 (UB-04) claim form or provide as much information as possible stating in "Locator 84" the reason for voiding the claim, previous payment will be deducted from current payments.

Examples of reason(s) an adjustment or void claim should be prepared and submitted:

1) Void - wrong recipient number or wrong provider number was used on the claim or entered incorrectly by the Medical Assistance program.

2) Adjustment - late charges, 3rd party payment was received or principle diagnosis was incorrect.

MANDATORY:

The provider **MUST** attach the Medicare Explanation of Benefits and any applicable third party explanation of benefits to **EACH** claim form.